The Fertility Center
William Dodds, MD, James Young, MD
Valerie Shavell, MD, and Richard Leach, MD

3230 Eagle Park Dr. NE
Suite 100
Grand Rapids MI 49525
Phone: 616-988-2229
Fax: 616-988-2010

1100 S Cedar St.
Suite 2
Mason MI 48854
Phone: 877-904-4483

317 S. Drake Rd.
Suite B
Kalamazoo MI 49009
Phone: 269-324-5100
Fax: 269-324-5041

Authorization to Release Medical Information

I, _____, DOB:_____, authorize The Fertility Center to release my records, including all medical records in your possession concerning my illness and/or treatment during the period from: _____ to: _____. My appointment is on_____ (date).

Physician: _____
Address: _____
Phone: _____
Fax: _____

Records to include:

- Any infertility testing or treatment
- Embryology reports (if patient has previously undergone IVF)
- Any records related to pregnancy or pregnancy loss
- Any gynecological radiology reports
- Any genetic testing
- Any documentation of medical problems that may affect a pregnancy or an attempt to become pregnant
- Communicable disease infection information, as defined by statute and Michigan Department of Public Health Rules (which include venereal disease, tuberculosis, hepatitis, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS" and AIDS related complex)
- Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2
- Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

Name_____ Date _____

Address _____

Signature _____